DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	I i		(X3) DATE	I	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15E594	A. BUI	LDING	00	COMP1 05/13/2	
		13E394	B. WIN			03/13/2	2011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MCGIVNI	EY HEALTH CARE	CENTER		I	AST 136TH STREET EL, IN46033		
					-L, IIV + 0033		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		DATE
F0000	REGGE HORT OR	230 122111 111.0 111 01411 11101.	1				D.H.L
1 0000							
	This visit was for	r the Investigation of	FO	000			1
	Complaint IN00089855.						
	•						
	Complaint IN00089855 substantiated,						
	Federal deficience						
		ted at F221, F224 and					
	F225.						
	Survey dates: May 12 and 13, 2011						
	2011						
	Facility number:	000545					
	Provider number						
	AIM number: 10	0267350					
	Survey team:						
	Rita Mullen, RN.	, TC					
	Census bed type:						
	NF: 29						
	Total: 29						
	Census payor typ	oe:					
	Medicaid: 26						
	Other: 3						
	Total: 29						
	Sample: 3						
	-						
	These deficiencie	es also reflect state					
	findings cited in	accordance with 410 IAC					
	16.2.						
LABORATOR'	V DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W3F311

Facility ID:

000545

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 05/13/2011
		15E594	B. WING		05/13/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
MCGIVN	EY HEALTH CARE	CENTER	I	EAST 136TH STREET IEL, IN46033	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDENCE NAVO CO CONTROLLO	(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	•	ompleted on May 17,			
	2011 by Bev Fau	lkner, RN			
F0221		he right to be free from any imposed for purposes of			
SS=D		enience, and not required to			
		medical symptoms.			
	Based on record	review and interview, the	F0221	Disclaimer:Preparation,	06/12/2011
	•	ensure a restraint was not		submission and implementation of this Plan of Correction do	•
		ence by nursing staff for		constitute an admission of o	I
		eviewed for physical		agreement with the facts and	t l
	restraints in a san	nple of 3. (Resident B)		conclusions set forth on the	
				survey report. Our Plan of Correction is prepared and	
	Findings include:	:		executed as a means to	
				continuously improve the qu	
	•	ew with the Executive		of care and to comply with a applicable state and federal	il
	`	istrator), on 5/12/11 at		regulatory requirements.F 22	21 It
	•	indicated there had been		is the policy of the facility to	
		24/11, regarding the		ensure all residents the right	l l
		lent B with a sheet tied		free from physical restraint a that restraints are not applied	l l
	around nim to ke	ep him from standing up.		staff convenience. The facil	l l
	Davious of the fee	cility investigation, dated		reported this issue to ISDH.	1.
		d it was started by Social		The facility is a physical restraint-free building and, a	
		lay, 4/25/11, the day after		such, does not use physical	
		investigation indicated		restraints on residents. Res	ident
		nday, 4/24/11, at noon.		B was removed from the) who
		wanted to restrain the		restraint. The Charge Nurse instructed the CNAs and allo	l l
	-	he kept getting up from		the restraint on the resident	
		nd setting off the personal		longer employed at the facili	•
	wilcolonair ui	is seeing off the personal		The CNAs involved in this is	sue

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15F594 05/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2907 EAST 136TH STREET MCGIVNEY HEALTH CARE CENTER CARMEL, IN46033 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE alarms. The charge nurse wanted a gait were re-in-serviced on the facility being a physical restraint-free belt to tie the resident in the wheel chair environment, stopping and but an extra one could not be found. She reporting abuse immediately. 2. used a sheet, tied around his chest and No other residents were affected by this practice.3. The Facility's knotted behind the wheel chair. He was Abuse Policy and Procedure was taken into the dining room, where he ate, reviewed and revised.All Staff and was then taken back to his room and in-service conducted on: What is put in bed. He was restrained for 15 to 20 Elder Abuse and the Signs of minutes Elder AbuseThe Facility's Abuse Policy and Procedure with Special Emphasis on being a Physical The clinical record of Resident B was Restraint-Free Environment, reviewed on 5/12/11 at 10:00 A.M. Stopping and Reporting Abuse Immediately4. All staff are responsible to stop abuse and Diagnoses for Resident B included, but report abuse immediately. Staff were not limited to, restless leg syndrome, failing to adhere to the facility dementia, anxiety, behaviors and chronic Abuse Policies and Procedures will be counseled by their pain. Supervisor/designee up to and including termination. Staff A quarterly Minimum Data Set in-service on What is Elder Abuse assessment, dated 4/12/11, indicated and the Signs of Elder Abuse and Resident B was severely cognitively The Facility's Abuse Policy and Procedure with Special Emphasis impaired and required the assistance of on being a Physical one staff member for activities of daily Restraint-Free Environment, living. Stopping and Reporting Abuse Immediately conducted in May/June and will be repeated in A Care Plan, dated 1/17/11 and last July 2011 by the SSD/DON. The updated 4/17/11, indicated Resident B had Quality Assurance Committee will a potential for falls...Approaches monitor compliance of the facility included, but were not limited to, "...gait Abuse Policy and Procedure on a quarterly basis. The belt [with] all transfers, medicated as DON/designee is the Abuse ordered with anti-psychotic. Notify Investigation Coordinator. Staff physician of any change in will receive Abuse Prohibition behavioral/mental status, bed and wheel Training upon hire, annually and as needed. chair alarm..., and ambulate [after]

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15E594	B. WIN			05/13/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIER	8			AST 136TH STREET		
MCGIVN	EY HEALTH CARE	CENTER		1	EL, IN46033		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	meals"						
	A review of the 1	Nursing notes for April 23					
		not indicate the resident					
	· ·	haviors or that he had to					
	be restrained for						
	oc restrained for	saicty.					
	During on interes	ion with CNA #2 on					
	_	iew with CNA #2, on					
		A.M., she indicated the					
	_	'N #1, told her "We have					
	1	strained." He was hitting					
		ie the sheet, I left the					
	room. I know no	w that I should have					
	called someone.'	•					
	During an interv	iew with CNA #4, on					
	5/13/11 at 9:45 A	A.M., she indicated the					
		n getting up, out of his					
		causing the alarm to					
		rge nurse told us we had					
		•					
		The nurse, LPN #1, took					
		and used a sheet to					
		e sheet was round his					
		hind the wheel chair. He					
	was restrained at	oout 15 - 20 minutes. It					
	happened on Sur	nday at noon. We told the					
	nurse, "We can't	restrain him" but she said					
	she was going to	do it anyway.					
	During an interv	iew with the Executive					
	_	2/11 at 10:30 A.M., she					
	1	se had resigned during					
		of the incident and the					
	_	mined and was not					
	resident was exa	iiiiicu anu was not					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED		
MIDILAN	or connection	15E594	A. BUILDING B. WING	00	05/13/2011
	PROVIDER OR SUPPLIER		STREET A 2907 E	ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET EL, IN46033	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0224 SS=D	The facility must d written policies and mistreatment, neg and misappropriat Based on and interv facility faithe staff for facility por reporting facility ad for inapprestraining resident.	iled to ensure ollowed the olicy in a nurse to the ministration	F0224	Disclaimer:Preparation, submission and implementat of this Plan of Correction doe constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the qua of care and to comply with all applicable state and federal regulatory requirements. F 22 is the policy of the facility to ensure all residents the right free from physical restraint a that restraints are not applied staff convenience. The facility reported this issue to ISDH.1 The facility is a physical restraint-free building and, as such, does not use physical restraints on residents. Resi	es not r d ality II 24 It to be ind d for ity I.

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		15E594	A. BUI B. WIN	LDING G		05/13/2011
NAME OF F	PROVIDER OR SUPPLIER		-!	1	ADDRESS, CITY, STATE, ZIP CODE	· ·
MCGIVN	EY HEALTH CARE	CENTER			AST 136TH STREET EL, IN46033	
(X4) ID		TATEMENT OF DEFICIENCIES		ID I		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	B was removed from the	DATE
	for restrai	nts in a sample			restraint. The Charge Nurs	
	of 3. (Res	ident B)			instructed the CNAs and all the restraint on the resident	
		,			longer employed at the facil	ity.
				The CNAs involved in this is were re-in-serviced on the fa		
	Findings i	nclude:			being a physical restraint-fre	- I
					environment, stopping and reporting abuse immediately	y. 2.
	A facility	Policy for			No other residents were affe	
					by this practice.3. The Facil Abuse Policy and Procedure	· 1
	"Reportable Unusual reviewed and revised. All Staff in-service conducted on: What is				****	
	Occurrence	es," dated			Elder Abuse and the Signs	of
	1/25/2006	with an			Elder AbuseThe Facility's Al Policy and Procedure with S	
	addendum				Emphasis on being a Physic Restraint-Free Environment	
					Stopping and Reporting Abu	
	10/23/09,	received from			Immediately4. All staff are responsible to stop abuse a	nd
	the Execu	tive Director,			report abuse immediately. failing to adhere to the facili	Staff
	on 5/12/11	l, indicated the			Abuse Policies and Procedu	-
	following				will be counseled by their Supervisor/designee up to a	and
	lonowing	•			including termination. Staff in-service on What is Elder.	
					and the Signs of Elder Abus	
	" Facility	Reporting and			The Facility's Abuse Policy of Procedure with Special Emp	
					on being a Physical	
	Investigation				Restraint-Free Environment Stopping and Reporting Abu	•
	Instruction	ns:			Immediately conducted in	
					May/June and will be repea July 2011 by the SSD/DON.	
	Facility must contact the				Quality Assurance Committe	ee will
		iasi contact the			monitor compliance of the fa Abuse Policy and Procedure	
					,	

000545

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE : COMPL		
		15E594	A. BUI B. WIN	LDING IG		05/13/2	
	PROVIDER OR SUPPLIER EY HEALTH CARE			2907 E	ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET EL, IN46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	ISDHwi	thin 24 hours			quarterly basis.The DON/designee is the Abuse		
	upon deter	rmining a		Investigation Coordinator. Staff will receive Abuse Prohibition			
	situation e	exists (or			Training upon hire, annually as needed	and	
	existed) th	nat is					
	reportable) <u>.</u>					
	All staff are						
	responsibl	le to report any					
	abuse to the	he Charge					
	Nurse imr	nediately. The					
	Charge Nu	urse is to					
	immediate	ely contact the					
	DON [Dir	ector of					
	Nursing],	who is the					
	Abuse Co	ordinator,					
	and/or the	Administrator					
	if the DO	N is					
	unreachab	ole."					
	During an	interview with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			SURVEY ETED	
		15E594	B. WIN	G		05/13/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET		
MCGIVN	EY HEALTH CARE	CENTER		CARME	EL, IN46033		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	ME.	DATE
	the facility	y Executive					
	Director, of	on 5/12/11 at					
	10:30 A.M						
	indicated	there had been					
	an inciden	nt on 4/24/11,					
	regarding	the restraint of					
	Resident I						
	tied aroun	d him to keep					
	him from	standing up.					
	The clinic	al record of					
	Resident I	B was reviewed					
	on 5/12/11	1 at 10:00 A.M.					
	,						
	Diagnoses	s for Resident					
		d, but were not					
		,					
	limited to, restless leg						
		, dementia,					
	•	ehaviors and					
	chronic pa	in.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E594		(X2) MULT A. BUILDIN B. WING		NSTRUCTION 00	(X3) DATE S COMPL 05/13/20	ETED	
	PROVIDER OR SUPPLIER EY HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2907 EAST 136TH STREET CARMEL, IN46033				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	A quarterl	y Minimum					
	Data Set a	issessment,					
	dated 4/12	2/11, indicated					
	Resident I	B was severely					
	cognitivel	y impaired and					
	required the assistance of						
	one staff r	nember for					
	activities of	of daily living.					
		-					
	A Care Pla	an, dated					
	1/17/11 ar	nd last updated					
	4/17/11, in	ndicated					
	Resident I	B had a					
	potential f	for					
	fallsApp	oroaches					
	included,	but were not					
	limited to,	, "gait belt					
	[with] all	transfers,					
	medicated	l as ordered					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/13/2011	7
	PROVIDER OR SUPPLIER		2907 E	ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET EL, IN46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPORIATE	(X5) PLETION ATE
	with anti-	psychotic.				
	Notify ph	ysician of any				
	change in					
	behaviora	l/mental status,				
	bed and w	heel chair				
	alarm, a	nd ambulate				
	[after] meals"					
	During an	interview with				
	CNA #2, o	on 5/13/11 at				
	9:15 A.M	., she indicated				
	the charge	nurse, LPN				
	#1, told he	er "We have to				
	get this gu	ıy restrained."				
	He was hi	tting at staff. "I				
	didn't tie t	he sheet, I left				
	the room.	I know now				
	that I shou	ıld have called				
	someone.'	1				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL	
		15E594	A. BUII B. WIN			05/13/20	011
NAME OF F	PROVIDER OR SUPPLIER		·	1	ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET	•	
MCGIVN	EY HEALTH CARE	CENTER		1	EL, IN46033		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	During an	interview with					
	CNA #4, o	on 5/13/11 at					
	9:45 A.M., she indicated						
	the resider	nt had been					
	getting up	, out of his					
	wheel chair and causing						
	the alarm to sound. "The						
	charge nurse told us we						
	had to rest	train him." The					
	nurse, LP	N #1, took him					
	to his room	m and used a					
	sheet to re	estrain him.					
	The sheet	was round his					
	chest and	tied behind the					
	wheel cha	ir. He was					
	restrained	about 15 - 20					
	minutes. I	t happened on					
	Sunday at	noon.					
	During an	interview with					
	_						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET EL, IN46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	the Execu	tive Director,					
	on 5/12/11	1 at 10:30					
	A.M., she	indicated a					
	nurse had	come to her on					
	the morni	ng of $4/25/11$,					
	and said s	he had over					
	heard some CNAs talking that morning						
	about wha	nt had					
	happened	over the					
	weekend.	A resident had					
	been restr	ained with a					
	sheet or g	ait belt. The					
	staff that l	nad worked the					
	weekend v	were called but					
	didn't resp	ond until					
	4/26/11.						
	The facili	ty					
	investigat	ion, dated					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	00	COMP:	LETED	
		15E594	B. WIN			05/13/2	2011
NAME OF I	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
MCGIVN	EY HEALTH CARE	CENTER		1	EL, IN46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	4/27/11, v	vas started by					
	Social Service on						
	Monday,	4/25/11, the					
	day after t	the incident.					
	The invest	tigation					
	indicated	this happened					
	Sunday, the 4/24/11, at						
	noon. The	charge nurse					
	wanted to	restrain the					
	resident b	ecause he kept					
	getting up	from his					
	wheelchai	ir and setting					
	off the per	rsonal alarms.					
	The charg	e nurse wanted					
	a gait belt	to tie the					
	Resident i	n the wheel					
	chair but a	an extra one					
	could not	be found. She					
	use a shee	et, tied around					
	his chest a	and knotted					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E594		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMP: 05/13/2	LETED	
	PROVIDER OR SUPPLIER		2907 E	ADDRESS, CITY, STATE, ZIP COD AST 136TH STREET EL, IN46033	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	behind the	e wheel chair.				
	He was ta	ken into the				
	dining roo	om, where he				
	ate, and w	as then taken				
	back to hi	s room and put				
	in bed. He	e was restrained				
	for 15 to 2	20 minutes.				
	This Fede	ral tag relates				
	to Compla	aint				
	IN000898	355.				
	3.1-28(a)					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CON	ISTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITTI DIDIC	,	00	COMPL	ETED
		15E594	A. BUILDING B. WING	'		05/13/2	011
				EET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L					
MCCIVAII	EY HEALTH CARE	CENTED			ST 136TH STREET		
INICGIVINI	ET HEALTH CARE	CENTER	L	KIVIEL	L, IN46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAC	ì	DEFICIENCY)		DATE
F0225	•	ot employ individuals who					
SS=D		guilty of abusing, neglecting,					
	or mistreating residents by a court of law; or						
		g entered into the State					
		concerning abuse, neglect,					
		esidents or misappropriation and report any knowledge it					
		a court of law against an					
		would indicate unfitness for					
		e aide or other facility staff to					
	the State nurse aide registry or licensing authorities.						
		nsure that all alleged					
		g mistreatment, neglect, or					
		njuries of unknown source					
		ion of resident property are					
	•	tely to the administrator of					
		other officials in accordance ough established procedures					
		tate survey and certification					
	agency).	tate survey and certification					
	agonoy).						
	The facility must h	ave evidence that all					
		are thoroughly investigated,					
	-	further potential abuse while					
	the investigation is	s in progress.					
		nvestigations must be					
	•	ministrator or his designated					
	•	d to other officials in					
		State law (including to the					
		certification agency) within 5					
		e incident, and if the alleged appropriate corrective					
	action must be tak						
			F0225		Disclaimer:Preparation,		06/12/2011
	Rased	on record	1 0223		submission and implementat	ion	00/12/2011
	Dasca (on record			of this Plan of Correction does not		
	•	1			constitute an admission of or		
	review	and			agreement with the facts and		
					conclusions set forth on the		

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	OI CORRECTION	15E594		LDING	00	05/13/2011
		.52501	B. WIN		ADDRESS CITY STATE ZIN CONF	1 33/13/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
MCGIVN	EY HEALTH CARE	CENTER	2907 EAST 136TH STREET CARMEL, IN46033			
				ID I		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
	intervi	ew, the			survey report. Our Plan of Correction is prepared and executed as a means to	
	facility	failed to			continuously improve the question of care and to comply with applicable state and federa	all I
	ensure the staff				regulatory requirements.F 2 is the policy of the facility to ensure all residents the right	
					free from physical restraint	and
	immediately				that restraints are not applied staff convenience. The fact	
					reported this issue to ISDH	•
	reported a nurse,				The facility is a physical	
					restraint-free building and,	
	to the f	acility			such, does not use physica restraints on residents. Re	ı
					B was removed from the	old of it.
	ladmini	stration,			restraint. The Charge Nurs	
		2 0 1 0 0 1 1 1 9			instructed the CNAs and all the restraint on the resident	
	for				longer employed at the faci	
	101				The CNAs involved in this i	- I
	inonnr	nriotaly			were re-in-serviced on the t	, I
	mappro	opriately			being a physical restraint-fr environment, stopping and	ee
		•			reporting abuse immediatel	y. 2.
	restrair	nng a			No other residents were aff	
		1			by this practice.3. The Faci Abuse Policy and Procedur	· 1
	confuse	ed			reviewed and revised.All St	ı
					in-service conducted on: W	hat is
	Reside	nt. This			Elder Abuse and the Signs	
		111. 11113			Elder AbuseThe Facility's A Policy and Procedure with	
	impacted 1 of 3				Emphasis on being a Physi	
					Restraint-Free Environmen	t,
		4			Stopping and Reporting Ab	use
	residen	ITS			Immediately4. All staff are responsible to stop abuse a	and
					report abuse immediately.	
					failing to adhere to the facil	
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	W3F311	Facility	ID: 000545 If continuation	sheet Page 16 of 28

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	ILTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THIS TELLY	or condition	15E594	A. BUILI B. WING			05/13/2011
	PROVIDER OR SUPPLIER		p. wind	STREET A 2907 EA	DDRESS, CITY, STATE, ZIP CODE AST 136TH STREET EL, IN46033	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	reviewe restrain sample (Reside	of 3.			Abuse Policies and Procedur will be counseled by their Supervisor/designee up to an including termination. Staff in-service on What is Elder A and the Signs of Elder Abuse The Facility's Abuse Policy a Procedure with Special Empon being a Physical Restraint-Free Environment, Stopping and Reporting Abuse Immediately conducted in	nd Abuse e and ind hasis
	Finding	ings include:			May/June and will be repeate in July 2011 by the SSD/DO! The Quality Assurance Committee will monitor compliance of the facility Abu Policy and Procedure on a quarterly basis.The DON/designee is the Abuse	N. use
	During	an		Investigation Coordinator. Staff will receive Abuse Prohibition Training upon hire, annually and	n	
	intervie	ew with the			as needed.	
	facility	Executive				
	Directo	or, on				
	5/12/11	at 10:30				
	A.M., s	she				
	indicate	ed there				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	CON	TE SURVEY MPLETED 3/2011	
	PROVIDER OR SUPPLIER		STREET 2907 E	ADDRESS, CITY, STATE, ZIP C EAST 136TH STREET EL, IN46033	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETION DATE	
	had bee	en an				
	inciden	it, on				
	4/24/11	- •				
	regardi	ng the				
	restrair	nt of				
	Resident B with a					
	sheet ti	ed around				
	him to	keep him				
	from st	anding up.				
	She inc	licated a				
	nurse h	ad come				
	to her o	on the				
	mornin	g of				
	4/25/11	, and said				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MULTIP A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		STF 29	07 E	ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET EL, IN46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	she had	lover					
	heard s	ome					
	CNAs	talking that					
	mornin	g about					
	what ha						
	happened over						
	the wee	ekend. A					
	residen	t had been					
	restrair	ned with a					
	sheet o	r gait belt.					
	"The C	NAs did					
	not call	l me."					
	During	an					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		2907 E	ADDRESS, CITY, STATE, ZIP C AST 136TH STREET EL, IN46033	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	intervi	ew with				
	CNA#	2, on				
	5/13/11	at 9:15				
	A.M., s	she				
	indicated the charge nurse,					
	LPN #3	l, told her				
	"We ha	ve to get				
	this gu	y				
	restrair	ned." He				
	was hit	ting at				
	staff. "	I didn't tie				
	the she	et, I left				
	the roo	m. I know				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/13/2011	
	PROVIDER OR SUPPLIER		STREET 2907 E	ADDRESS, CITY, STATE, ZIP CO AST 136TH STREET EL, IN46033	DDE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE COMPLETION
	now the	at I should			
	have called				
	someone."				
	During	an			
	intervie	ew with			
	CNA#	4, on			
	5/13/11	at 9:45			
	A.M., s	she			
	indicate	ed the			
	residen	t had been			
	getting	up, out of			
	his whe	eel chair			
	and cau	using the			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594			LDING	NSTRUCTION 00	CO	DATE SURVEY DMPLETED 13/2011	
	PROVIDER OR SUPPLIER			2907 E	ADDRESS, CITY, STATE, ZIP CODI AST 136TH STREET EL, IN46033	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	alarm t	o sound.					
	"The cl	narge nurse					
	told us	we had to					
	restrair	him." The					
	nurse, LPN #1,						
	took him to his						
	room a	nd used a					
	sheet to	restrain					
	him. Tl	ne sheet					
	was rou	and his					
	chest a	nd tied					
	behind	the wheel					
	chair. I	He was					
	restrair	ned about					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		nstruction 00	(X3) DATE S COMPL	ETED
		15E594	B. WING			05/13/2	011
NAME OF P	ROVIDER OR SUPPLIER		ı		DDRESS, CITY, STATE, ZIP CODE ST 136TH STREET		
MCGIVN	EY HEALTH CARE	CENTER	CA	RME	L, IN46033		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAC	- 1	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	15 - 20	minutes.					
	It happened on						
	Sunday at noon.						
	The clinical						
	record	of					
	Resider	nt B was					
	review	ed on					
	5/12/11	at 10:00					
	A.M.						
	Diagno	ses for					
	Reside						
	include	ed, but					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ì		INSTRUCTION 00	(X3) DATE S COMPL	
		15E594	A. BUII B. WIN			05/13/2	011
NAME OF F	PROVIDER OR SUPPLIER		·		ADDRESS, CITY, STATE, ZIP CODE AST 136TH STREET	•	
MCGIVN	EY HEALTH CARE	CENTER		1	EL, IN46033		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	JΈ	DATE
	were no	ot limited					
	to, rest	less leg					
	syndrome,						
	dementia,						
	anxiety,						
	behaviors and						
	chronic	pain.					
	A quart	terly					
	Minim	um Data					
	Set asso	essment,					
	dated 4	/12/11,					
	indicate	ed					
	Reside	nt B was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MULTIPLE CO A. BUILDING B. WING	00	ì í	E SURVEY PLETED (2011	
	PROVIDER OR SUPPLIER		2907 E	ADDRESS, CITY, STATE, ZIP C EAST 136TH STREET EL, IN46033	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	severel	У				
	cognitively					
	impaire	ed and				
	require	d the				
	assistai	nce of one				
	staff m	ember for				
	activiti	es of daily				
	living.					
	last upo 4/17/11	/17/11 and				

000545

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COM	(X3) DATE SURVEY COMPLETED 05/13/2011		
NAME OF PROVIDER OR SUPPLIER MCGIVNEY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 EAST 136TH STREET CARMEL, IN46033					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	potenti	al for						
	falls <i>F</i>	Approaches						
	include	ed, but						
	were no	ot limited						
	to, "g	gait belt						
	[with] all							
	transfers,							
	medicated as							
	ordered with							
	anti-psychotic.							
	Notify	physician						
	of any	change in						
	behavio	oral/mental						
	status,	bed and						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMP	LETED		
	15E594		A. BUILDING B. WING			05/13/2011		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
MCGIVNEY HEALTH CARE CENTER			2907 EAST 136TH STREET CARMEL, IN46033					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	wheel o	chair						
	alarm, and							
	ambulate [after]							
	meals	"						
	A review of the							
	Nursing notes for							
	April 23 and 24,							
	2011 did not							
	indicate the							
	residen	t had						
	increas	ed						
	behavio	ors, or that						
	he had	to be						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		A. BUILDING B. WING		COMP	COMPLETED 05/13/2011		
NAME OF PROVIDER OR SUPPLIER MCGIVNEY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 EAST 136TH STREET CARMEL, IN46033				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	restrain	ned for					
	safety.						
	Thic Fe	ederal tag					
	relates						
	Compla						
	IN0008						
	3.1-28((c)					